

		FOR OFF USE				

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0039636</u></p> <p>Facility Name: <u>Cahokia Nursing & Rehabilitation Center</u></p> <p>Address: <u>2 Annabelle Court</u> <u>Cahokia</u> <u>62206</u> Number City Zip Code</p> <p>County: <u>St. Clair</u></p> <p>Telephone Number: <u>(618) 332-0114</u> Fax # <u>(618) 332-1043</u></p> <p>IDPA ID Number: <u>363952442001</u></p> <p>Date of Initial License for Current Owners: <u>06/01/1994</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-4580</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 30%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td colspan="2"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Date) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center# 0039636 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>150</u>	Skilled (SNF)	<u>150</u>	<u>54,750</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,750</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,996</u>	<u>361</u>	<u>4,102</u>	<u>8,459</u>	8
9	SNF/PED					9
10	ICF	<u>32,617</u>	<u>429</u>	<u>41</u>	<u>33,087</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>36,613</u>	<u>790</u>	<u>4,143</u>	<u>41,546</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 75.88%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location

Date started 06/01/1994

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 06/01/1994NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 30 and days of care provided 3,529Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year YES ☒ NO ☐Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	201,007	12,543	3,951	217,501		217,501		217,501		1
2	Food Purchase		170,812		170,812		170,812	(3,939)	166,873		2
3	Housekeeping	140,727	67,646		208,373		208,373	280	208,653		3
4	Laundry	58,669	24,430		83,099		83,099		83,099		4
5	Heat and Other Utilities			121,029	121,029		121,029	1,993	123,022		5
6	Maintenance	29,872	37,320	13,246	80,438		80,438	621	81,059		6
7	Other (specify):*										7
8	TOTAL General Services	430,275	312,751	138,226	881,252		881,252	(1,045)	880,207		8
	B. Health Care and Programs										
9	Medical Director			2,100	2,100		2,100		2,100		9
10	Nursing and Medical Records	1,537,939	40,990	4,400	1,583,329		1,583,329	(1,584)	1,581,745		10
10a	Therapy			475,105	475,105		475,105		475,105		10a
11	Activities	61,758	5,896		67,654		67,654		67,654		11
12	Social Services	43,871			43,871		43,871		43,871		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,643,568	46,886	481,605	2,172,059		2,172,059	(1,584)	2,170,475		16
	C. General Administration										
17	Administrative	125,692		243,250	368,942		368,942	(132,929)	236,013		17
18	Directors Fees										18
19	Professional Services			73,703	73,703		73,703	(332)	73,371		19
20	Dues, Fees, Subscriptions & Promotion			3,354	3,354		3,354	12	3,366		20
21	Clerical & General Office Expense	275,072		33,141	308,213		308,213	68,301	376,514		21
22	Employee Benefits & Payroll Taxes			336,516	336,516		336,516	3,248	339,764		22
23	Inservice Training & Education										23
24	Travel and Seminars			1,932	1,932		1,932	37	1,969		24
25	Other Admin. Staff Transportation			1,471	1,471		1,471	324	1,795		25
26	Insurance-Prop.Liab.Malpractice			15,958	15,958		15,958	14,218	30,176		26
27	Other (specify):* Mgmt. Co. Benefits							14,920	14,920		27
28	TOTAL General Administration	400,764		709,325	1,110,089		1,110,089	(32,201)	1,077,888		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,474,607	359,637	1,329,156	4,163,400		4,163,400	(34,830)	4,128,570		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

#0039636

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			87,199	87,199		87,199	109,581	196,780			30
31	Amortization of Pre-Op. & Org											31
32	Interest			37,286	37,286		37,286	236,758	274,044			32
33	Real Estate Taxes							180,804	180,804			33
34	Rent-Facility & Grounds			600,000	600,000		600,000	(600,000)				34
35	Rent-Equipment & Vehicle							1,168	1,168			35
36	Other (specify): ³ Mortgage Ins.							19,196	19,196			36
37	TOTAL Ownership			724,485	724,485		724,485	(52,493)	671,992			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Center:		112,496		112,496		112,496		112,496			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify): ³ Nonallowable Cost			34,518	34,518		34,518	(34,518)				43
44	TOTAL Special Cost Centers		112,496	116,643	229,139		229,139	(34,518)	194,621			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,474,607	472,133	2,170,284	5,117,024		5,117,024	(121,841)	4,995,183			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See Schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(104,107)	30		9
10	Interest and Other Investment Income	(29)	32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(273)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(11,050)	43		18
19	Entertainment				19
20	Contributions	(25)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(6,406)	43		24
25	Fund Raising, Advertising and Promotion	(231)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See page 5A	(52,287)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (174,408)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	52,567		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 52,567		36
37	(sum of SUBTOTALS (A) and (B))	\$ (121,841)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport		x	\$		38
39						39
40	Gift and Coffee Shop		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing & Rehabilitation Center
Provider #: 0039636
01/01/2005 to 12/31/2005

Schedule 5A

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Legal - Out of Period	(7,633)	19
Chamber of Commerce dues	(50)	20
Related Party Interest Expense, Net of Interest Incom	(28,071)	32
Lab Expense	(9,940)	43
X-Ray Expense	(6,593)	43
	<u>(52,287)</u>	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

Cahokia Nursing & Rehabilitation Center

ID# 0039636

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Chamber of Commerce dues	\$ (50)	20	1
2	Labs - Part A	(9,940)	32	2
3	X-Rays - Part A	(6,593)	43	3
4	Political contributions	(25)	43	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(16,608)		49

Summary A

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Report Period Beginning:

Ending:

12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	\$	Cahokia Building LLC	100.00%	\$ 4,500	\$ 4,500	1
2	V	21	Clerical & General Office-Other		Cahokia Building LLC	100.00%	399	399	2
3	V	26	Insurance-Prop.Liab.Malpractice		Cahokia Building LLC	100.00%	13,046	13,046	3
4	V	30	Depreciation		Cahokia Building LLC	100.00%	209,718	209,718	4
5	V	32	Interest income	903	Cahokia Building LLC	100.00%		(903)	5
6	V	32	Interest		Cahokia Building LLC	100.00%	264,300	264,300	6
7	V	33	Real Estate Tax		Cahokia Building LLC	100.00%	177,219	177,219	7
8	V	34	Rent	600,000	Cahokia Building LLC	100.00%		(600,000)	8
9	V	36	Mortgage Insurance		Cahokia Building LLC	100.00%	19,196	19,196	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 600,903			\$ 688,378	\$ * 87,475	14

* Total must agree with the amount recorded on line 34 of Schedule V1

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing & Rehabilitation Center

0039636

12/31/2005

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis

Out-of-State:

St. Elizabeth Healthcare Center	Florissant, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO

Other Related Business Entities

S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$	S.W. Management Co.	100.00%	\$ (25)	\$ (25)
16	V	3 Housekeeping		S.W. Management Co.	100.00%	280	280
17	V	5 Heat and Other Utilities		S.W. Management Co.	100.00%	1,993	1,993
18	V	6 Maintenance		S.W. Management Co.	100.00%	621	621
19	V	17 Administrative	183,250	S.W. Management Co.	100.00%	50,321	(132,929)
20	V	19 Professional Services		S.W. Management Co.	100.00%	2,801	2,801
21	V	20 Dues, Fees, Subs & Promotions		S.W. Management Co.	100.00%	62	62
22	V	21 Clerical & General Office Expense		S.W. Management Co.	100.00%	67,902	67,902
23	V	24 Travel and Seminar		S.W. Management Co.	100.00%	37	37
24	V	25 Other Admin. Staff Transport		S.W. Management Co.	100.00%	324	324
25	V	26 Insurance-Prop.Liab.Malpractice		S.W. Management Co.	100.00%	1,172	1,172
26	V	27 Mgmt. Allocation of Benefits		S.W. Management Co.	100.00%	14,920	14,920
27	V	30 Depreciation		S.W. Management Co.	100.00%	3,970	3,970
28	V	32 Interest		S.W. Management Co.	100.00%	1,461	1,461
29	V	33 Real Estate Taxes		S.W. Management Co.	100.00%	3,585	3,585
30	V	35 Rent - Equipment & Vehicles		S.W. Management Co.	100.00%	1,168	1,168
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 183,250			\$ 150,592	\$ * (32,658)

* Total must agree with the amount recorded on line 34 of Schedule V1

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center# 0039636Report Period Beginning: 01/01/2005Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 Food	\$ 11,145	S & E Medical Supply Co.	100.00%	\$ 10,479	\$ (666)	15
16	V	3 Housekeeping	3,212	S & E Medical Supply Co.	100.00%	3,212		16
17	V	10 Medical Supplies	6,281	S & E Medical Supply Co.	100.00%	4,697	(1,584)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 20,638			\$ 18,388	\$ * (2,250)	39

* Total must agree with the amount recorded on line 34 of Schedule V1

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	3	7.00	Salary	\$ 50,321	L17,C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	3.5	9.00	Salary&Fees	65,250	17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	4.2	10.00	Salary	15,579	L21,C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 131,150		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.W. Management Co.
 Street Address 7434 N. Skokie Blvd.
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 982-2300
 Fax Number (847) 982-2304

B. Show the allocation of costs below. If necessary, please attach worksheets

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	570,112	10	\$ (257)	\$	54,750	(25)	1
2	3	Housekeeping	Bed Days Available	570,112	10	2,912		54,750	280	2
3	5	Heat and Other Utilities	Bed Days Available	570,112	10	20,748		54,750	1,993	3
4	6	Maintenance	Bed Days Available	570,112	10	6,462		54,750	621	4
5	19	Professional Services	Bed Days Available	570,112	10	29,160		54,750	2,801	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	570,112	10	640		54,750	62	6
7	21	Clerical & General Office Exp	Bed Days Available	570,112	10	652,396	606,507	54,750	62,652	7
8	24	Travel and Seminar	Bed Days Available	570,112	10	384		54,750	37	8
9	25	Other Admin. Staff Transport	Bed Days Available	570,112	10	3,378		54,750	324	9
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	570,112	10	12,203		54,750	1,172	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	570,112	10	155,361		54,750	14,920	11
12	32	Interest	Bed Days Available	570,112	10	15,217		54,750	1,461	12
13	33	Real Estate Taxes	Bed Days Available	570,112	10	37,335		54,750	3,585	13
14	35	Rent - Equipment & Vehicles	Bed Days Available	570,112	10	12,167		54,750	1,168	14
15										15
16	17	Administrative	Avg. Hours Worked	44	10	738,036	738,036	3	50,321	16
17	21	Clerical & General Office Exp	Avg. Hours Worked	40	7	60,000	60,000	4	5,250	17
18										18
19	30	Depreciation	Direct Cost						3,970	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,746,142	\$ 1,404,543		\$ 150,592	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S & E Medical Supply Co.
 Street Address 3100 Commercial Avenue
 City / State / Zip Code Northbrook, IL 60062
 Phone Number (847) 982-9300
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 10,479	1
2	3	Housekeeping	Direct Cost					3,212	2
3	10	Medical Supplies	Direct Cost					4,697	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 18,388	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Heartland Bank-HUD		X	Mortgage	\$23,524.00	11/27/01	\$ 3,961,000	\$ 3,821,332	12/01/36	0.0635	\$ 243,783	1	
2	CCC Note Holders Assoc.		X	Second Mortgage	Varies	11/27/01	265,000	265,000	12/01/36	0.0500	16,205	2	
3								Amortization of mortgage costs			4,312	3	
4												4	
5												5	
	Working Capital												
6	N/P Stockholders	X		Working Capital				643,740			30,702	6	
7		X		Working Capital				Interest on intercompany accounts			6,584	7	
8												8	
9	TOTAL Facility Related				\$23,524.00		\$ 4,226,000	\$ 4,730,072				\$ 301,586	9
	B. Non-Facility Related*												
10							Allocation from SW Mgmt. - Mortgage				1,461	10	
11							Related party interest expense net of interest income				(28,071)	11	
12							Interest income offset				(29)	12	
13							Interest income offset from real estate entity				(903)	13	
14	TOTAL Non-Facility Related						\$	\$				\$ (27,542)	14
15	TOTALS (line 9+line14)						\$ 4,226,000	\$ 4,730,072				\$ 274,044	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,196 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Cahokia Nursing & Rehabilitation Center**# **0039636** Report Period Beginning: **01/01/2005** Ending: **12/31/2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report	\$	148,000	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2004	\$	160,219	2	
3. Under or (over) accrual (line 2 minus line 1).			\$	12,219	3	
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	165,000	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Home Office Allocation		3,585		
TOTAL REFUND	\$	For	Tax Year.	(Attach a copy of the real estate tax appeal board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	180,804	7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2000	115,983	8			
	2001	120,002	9			
	2002	125,340	10			
	2003	143,835	11			
	2004	160,219	12			
Accrual = 2004 tax bill 160,219 x 1.03 = 165,025						
Use - 165,000						

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

SEE ACCOUNTANTS' COMPILATION REPORT

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY IDPH LICENSE NUMBER 0039636

TELEPHONE (847) 982-2300 FAX #: (847) 932-2304

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)		(B)	(C)		(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>		<u>Tax Applicable to Nursing Home</u>
1.	10-28-412-049-0000	SW Management Allocation	\$	38,709.00	\$ 3,585.00
2.	06-02.0-310-055	Long-Term Care Property	\$	157,774.00	\$ 157,774.00
3.	06-02.0-310-054	Long-Term Care Property	\$	2,445.00	\$ 2,445.00
4.			\$		\$
5.			\$		\$
6.			\$		\$
7.			\$		\$
8.			\$		\$
9.			\$		\$
10.			\$		\$
TOTALS			\$	198,928.00	\$ 163,804.00

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Page 10A

provider name
provider #
12/31/2005

Schedule 10A

Allocation of Real Estate Tax Bill
S.W. Management Co.
Page 10, Line 2

Facility Name/ Real Estate Tax #	Basis of Allocation	Available Patient Days	% Allocated	Amount Allocated
10-28-412-049-0000				\$ 38,709
% Applicable to Long Term Care:	Home Office/Management Fee			<u>96.45%</u>
				<u>\$ 37,335</u>
Cahokia Nursing and Rehab	Available Patient Days	54,750	9.60%	3,585
Caseyville Nursing and Rehab	Available Patient Days	54,750	9.60%	3,585
Franklin Grove Nursing Center	Available Patient Days	44,165	7.75%	2,892
Hillside Manor Healthcare and Rehab	Available Patient Days	44,512	7.81%	2,915
Kenwood Healthcare Center	Available Patient Days	116,070	20.36%	7,601
Oregon Healthcare Center	Available Patient Days	37,960	6.66%	2,486
Shabbona Healthcare Center	Available Patient Days	33,215	5.83%	2,175
St. Elizabeth Healthcare Center	Available Patient Days	54,750	9.60%	3,585
Tower Hill Healthcare Center	Available Patient Days	75,190	13.19%	4,924
Virgil Calvert Nursing and Rehab	Available Patient Days	54,750	9.60%	3,585
		<u>570,112</u>	<u>100.00%</u>	<u>\$ 37,335</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization ☒ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		2001	\$ 230,000	1
2					2
3	TOTALS			\$ 230,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	150	2001		\$ 2,928,451		15-40	\$ 80,744	\$ 80,744	\$ 331,612
5									
6									
7	Mgmt.	1995		41,567		39	1,188	1,188	12,654
8	Allocation								
Improvement Type**									
9	Various	1994		17,847	268	20	523	255	13,327
10	Various	1995		33,623	337	20	1,681	1,344	18,049
11	Various	1996		2,178	56	20	109	53	1,054
12	Various	1997		9,423		20	471	471	4,007
13	Various	1998		4,800	123	20	240	117	1,800
14	Various	1999		16,265	93	20	813	720	5,471
15	Air Handler	2000		1,516		5			1,516
16	Alarm System	2001		1,908		5	167	167	1,908
17	Blind	2001		1,212		5	106	106	1,212
18	Air Handler	2001		1,317		20	66	66	297
19	Fan Motor	2001		1,123		20	56	56	229
20	Drywall-Dining Room	2002		10,650	368	10	1,065	697	4,083
21	Door	2002		9,860		20	493	493	1,520
22	Air Conditioner	2002		1,198		7	171	171	613
23	Air Conditioner	2002		1,582		7	226	226	810
24	Air Conditioners	2002		4,284		7	612	612	2,142
25	Compressor Air Max	2002		1,269		7	181	181	664
26	Roof - New	2003		97,996	2,513	20	4,900	2,387	13,475
27	Nursing Station	2003		35,060		20	1,753	1,753	4,090
28	Nursing Station	2003		28,692		20	1,435	1,435	4,544
29	Nursing Station	2003		6,368		20	318	318	663
30	Replace Accelerator	2003		968		20	48	48	144
31	Sprinkler System	2004		3,610	131	20	181	50	271
32	Smoke shelter	2004		6,041	220	20	302	82	453
33	Security System	2005		11,166	220	20	279	59	279
34	Condensing Unit - 5 Ton	2005		1,959	39	20	49	10	49
35	Cabinets and countertops	2005		110,923	2,173	20	2,773	600	2,773
36	Air Handler	2005		1,549	26	20	39	13	39

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Asphalt Parking Lot	2005	\$ 5,570	\$ 279	20	\$ 139	\$ (140)	\$ 139	37
38	A/C Unit 2 Tons	2005	1,092	15	20	27	12	27	38
39	Reframe & drywall 3 windows	2005	4,200	45	20	105	60	105	39
40	Carpet & Vinyl Floor	2005	4,390	4,390	20	110	(4,280)	110	40
41	Sprinkler System - new pipe	2005	1,463	11	20	37	26	37	41
42	Door Alarms	2005	3,587	27	20	90	63	90	42
43	Wallpaper	2005	17,835	17,835	20	446	(17,389)	446	43
44	Painting and Wallcovering	2005	29,600	29,600	20	740	(28,860)	740	44
45	6 Doors	2005	1,926	3	20	48	45	48	45
46	Plaster Ceiling	2005	10,392	16	20	260	244	260	46
47	Vinyl Flooring	2005	4,878	52	20	122	70	122	47
48									48
49									49
50	Allocated from SW Management - Leasehold Improvements	1995	4,435		20	222	222	2,675	50
51	Allocated from SW Management - Leasehold Improvements	1996	775		20	39	39	370	51
52	Allocated from SW Management - Leasehold Improvements	1997	1,115		20	56	56	612	52
53	Allocated from SW Management - Leasehold Improvements	1998	768		20	38	38	298	53
54	Allocated from SW Management - Leasehold Improvements	1999	2,132		20	107	107	649	54
55	Allocated from SW Management - Leasehold Improvements	2005	4,410		20	110	110	110	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,492,973	\$ 58,840		\$ 103,685	\$ 44,845	\$ 436,586	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component/ Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 822,346	\$ 14,724	\$ 90,202	\$ 75,478	10	\$ 542,308	71
72	Current Year Purchases	13,635	13,635	682	(12,953)	10	682	72
73	Fully Depreciated Assets							73
74	Allocation from Management Co.	11,220		1,098	1,098		10,241	74
75	TOTALS	\$ 847,201	\$ 28,359	\$ 91,982	\$ 63,623		\$ 553,231	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$			\$	76
77										77
78	Allocation from Mgmt. Co.	2004 Cadillac	2004	5,566		1,113	1,113	5	1,670	78
79										79
80	TOTALS			\$ 5,566	\$	1,113	1,113		\$ 1,670	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,575,740	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,199	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 196,780	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 109,581	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 991,487	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progres

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column f

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized
 by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ None Description: N/A
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19	SW Mgmt allocation			1,168	19
20					20
21	TOTAL		\$	\$ 1,168	21

10. Effective dates of current rental agreement:
 Beginning
 Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2006 \$
 13. /2007 \$
 14. /2008 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center # 0039636 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA _____
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefit.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefit.

(c) For in-house training programs only. Do not include fringe benefit.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities:

\$ _____

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					Units	Cost				
1	Licensed Occupational Therapist	10(A)3	hrs	\$	10,269	\$ 173,251	\$	10,269	\$ 173,251	1
2	Licensed Speech and Language Development Therapist	10(A)3	hrs		4,035	104,904		4,035	104,904	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10(A)3	hrs		11,838	189,411		11,838	189,411	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				112,496		112,496	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify):									13
14	TOTAL			\$	26,142	\$ 467,566	\$ 112,496	26,142	\$ 580,062	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed
Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed
on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,000	\$ 149,670	1
2	Cash-Patient Deposits	13,731	13,731	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	1,087,537	1,087,537	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,432	54,801	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	262,881	450,205	9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,395,581	\$ 1,755,944	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		230,000	13
14	Buildings, at Historical Cost		2,789,222	14
15	Leasehold Improvements, at Historical Cost	372,302	703,751	15
16	Equipment, at Historical Cost	353,109	852,767	16
17	Accumulated Depreciation (book methods)	(411,843)	(991,487)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) <u>Unamortized mortgage</u>		133,876	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 313,568	\$ 3,718,129	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,709,149	\$ 5,474,073	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 150,401	\$ 157,135	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,822	22,822	28
29	Short-Term Notes Payable	643,740	643,740	29
30	Accrued Salaries Payable	121,901	121,901	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,090	16,090	31
32	Accrued Real Estate Taxes(Sch.IX-B)		165,000	32
33	Accrued Interest Payable		95,534	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	534,796	135,694	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,489,750	\$ 1,357,916	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,086,332	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,086,332	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,489,750	\$ 5,444,248	46
47	TOTAL EQUITY (page 18, line 24)	\$ 219,399	\$ 29,825	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,709,149	\$ 5,474,073	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Cahokia Nursing & Rehabilitation Center**Provider #: 0039636****01/01/2005 to 12/31/2005****Schedule 17A**

XV. Balance Sheet

	Operating	After Consolidation
Line 9 - Other		
Escrow - Insurance	-	10,181
Escrow - Mortgage Insurance Premium	-	570
Replacement Reserve	-	140,613
Escrow - Real Estate Tax	-	35,960
Employee Loans	300	300
Short-term Loan Exchange	271,517	271,517
Due to Public Aid	(8,936)	(8,936)
	<u>262,881</u>	<u>450,205</u>
Line 36 - Other Current Liabilities		
Due to Cahokia Building LLC	(417,522)	(18,420)
Accrued expenses	<u>(117,274)</u>	<u>(117,274)</u>
	<u>(534,796)</u>	<u>(135,694)</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 85,582	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(34,014)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 51,568	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	167,831	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 167,831	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 219,399	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,924,883	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,924,883	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	334,111	6
7	Oxygen	15,329	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 349,440	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	9,244	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,244	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc income	1,288	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,288	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,284,855	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	881,252	31
32	Health Care	2,172,059	32
33	General Administration	1,110,089	33
B. Capital Expense			
34	Ownership	724,485	34
C. Ancillary Expense			
35	Special Cost Centers	147,014	35
36	Provider Participation Fee	82,125	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,117,024	40
41	Income before Income Taxes (line 30 minus line 40)**	167,831	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 167,831	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Cahokia Nursing & Rehabilitation Center**

0039636

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,912	2,080	\$ 59,619	\$ 28.66	1
2	Assistant Director of Nursing	1,904	2,080	53,512	25.73	2
3	Registered Nurses	4,550	4,833	120,330	24.90	3
4	Licensed Practical Nurses	21,710	23,081	435,319	18.86	4
5	CNAs & Orderlies	82,455	87,187	798,083	9.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,054	5,849	71,076	12.15	8
9	Activity Director					9
10	Activity Assistants	5,761	6,307	61,758	9.79	10
11	Social Service Worker	3,129	3,267	43,871	13.43	11
12	Dietician					12
13	Food Service Supervisor	1,725	1,945	26,075	13.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,962	20,501	174,932	8.53	15
16	Dishwashers					16
17	Maintenance Worker	2,314	2,532	29,872	11.80	17
18	Housekeepers	18,402	19,215	140,727	7.32	18
19	Laundry	8,651	8,891	58,669	6.60	19
20	Administrator	1,920	2,080	125,692	60.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,833	15,856	275,072	17.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	193,282	205,704	\$ 2,474,607 *	\$ 12.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 3,951	L1, C3	35
36	Medical Director	Monthly	2,100	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,400	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	558	7,539	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	558	\$ 17,990		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Robin Suydam	Administrator	0	125,692	Workers' Compensation Insurance		49,065	IDPH License Fee		995		
				Unemployment Compensation Insurance		67,380	Advertising: Employee Recruitment				
				FICA Taxes		187,058	Health Care Worker Background Check (Indicate # of checks performed 167)		1,659		
				Employee Health Insurance		24,601	Miscellaneous dues		470		
				Employee Meals		3,248	Miscellaneous dues & subscriptions		230		
				Illinois Municipal Retirement Fund (IMRF)*							
				Employee Morale		8,412					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.			125,692				Allocated from Home Office		62		
B. Administrative - Other							Less: Public Relations Expense		(50)		
Description			Amount				Non-allowable advertising		()		
SW Management			183,250				Yellow page advertising		()		
Ronnie Klein			60,000				TOTAL (agree to Sch. V, line 20, col. 8)		3,366		
				TOTAL (agree to Schedule V, line 22, col.8)		339,764					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**d				
C. Professional Services				Description		Line #	Description		Amount		
Vendor/Payee	Type		Amount				Out-of-State Travel				
American Express	Accounting		14,541								
Personnel Planners	Unemployment consultant		2,625				In-State Travel				
Winston & Strawn	Legal		1,312								
Ashman & Stein	Legal		10,062								
Tueth, Keeney, et.al.	Legal		39,114	N/A							
Foley & Lardner	Legal		315								
Burroughs, Helper, Broom, et al	Legal		5,734				Seminar Expense		1,932		
							Allocated from Home Office		37		
							Entertainment Expense		()		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			73,703	TOTAL			(agree to Sch. V, line 24, col. 8)		1,969		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

Cahokia Nursing & Rehabilitation Center

Provider #: 0039636

01/01/2005 to 12/31/2005

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	73,703
Allocated from Cahokia Building LLC - Accounting	4,500
Allocated from Management Company - Legal	1,448
Allocated from Management Company - Accounting	
AM&G/Amex/Frost, Rутtenberg & Rothblat	1,353
Less: Non-allowable legal expenses	(7,633)
 Total (agree to Schedule V, line 19, column 8)	 <u><u>73,371</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 6 7 8 9 10 11 12 13 Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5	N/A												
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing & Rehabilitation Center

0039636

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report No
If YES, give association name and amount N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases Yes
What was the average life used for new equipment added during this period 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. N/A Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,125
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? No If YES, attach an explanation of the allocation
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,248 Has any meal income been offset against related costs? No Indicate the amount \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel No
If YES, attach a complete explanation N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? N/A
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT

RECONCILIATION REPORT

10:24 AM 5/16/2006

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-121,841	equal to	-121,841	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	274,044	equal to	274,044	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	180,804	equal to	180,804	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	196,780	equal to	196,780	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	1,168	equal to	1,168	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	0	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	475,105	equal to	475,105	0	O.K.	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	112,496	equal to	112,496	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	881,252	equal to	881,252	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,172,059	equal to	2,172,059	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,110,089	equal to	1,110,089	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	724,485	equal to	724,485	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	147,014	equal to	147,014	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	82,125	equal to	82,125	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,466,863	equal to	1,537,939	-71,076	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	61,758	equal to	61,758	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	43,871	equal to	43,871	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	201,007	equal to	201,007	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	29,872	equal to	29,872	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	140,727	equal to	140,727	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	58,669	equal to	58,669	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	125,692	equal to	125,692	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	275,072	equal to	275,072	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,474,607	equal to	2,474,607	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	3,951	< or = to	3,951	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	2,100	< or = to	2,100	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,400	< or = to	4,400	0	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	0	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	125,692	equal to	125,692	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	243,250	equal to	243,250	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	73,703	equal to	73,703	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	339,764	equal to	339,764	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	3,366	equal to	3,366	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,969	equal to	1,969	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	82,125	equal to	82,125	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	3,248	< or = to	3,248	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	3,248	equal to	3,248	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	3,529	equal to	4,102	-573	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	52,567	equal to	52,567	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	4,730,072	equal to	4,730,072	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	165,000	equal to	165,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	230,000	equal to	230,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,492,973	equal to	3,492,973	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	852,767	equal to	852,767	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	991,487	equal to	991,487	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	219,399	equal to	219,399	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	167,831	equal to	167,831	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..1	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,709,149	equal to	1,709,149	0	O.K.	Pg17H41		25	1	Pg17 S41	N/A	48	1

Cahokia Nursing & Rehabilitation Center
IDPA Comparative Data - Per Resident Day Cost
Year Ending 12/31/2005

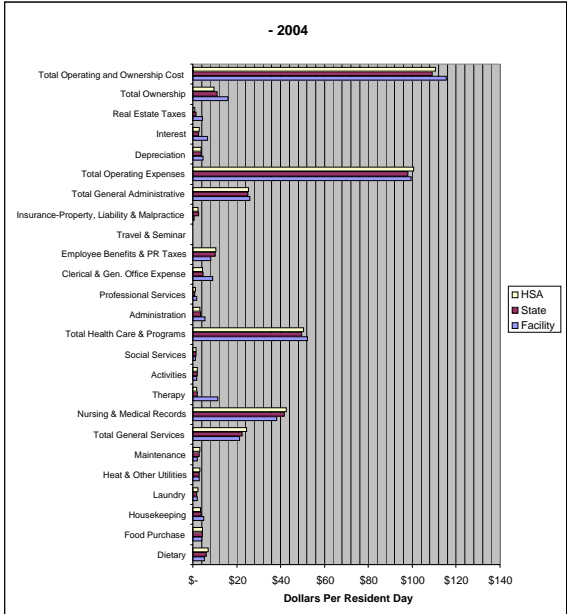
Enter your HSA # in next column
Census (Pulls from Page 2)

1

41,546

Cost Report Line	Description	Your Facility		Average Median Cost Per Day		HSA	IDPA LTC Profiles											LTC Median Per Diem Cost by HSA - 2003 Cost Reports		10th %	90th %																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																														
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1	Dietary	5.24	6.01	7.02																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															</

Notes:
Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.
The Average Median Cost Per Day for the State and your HSA is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.

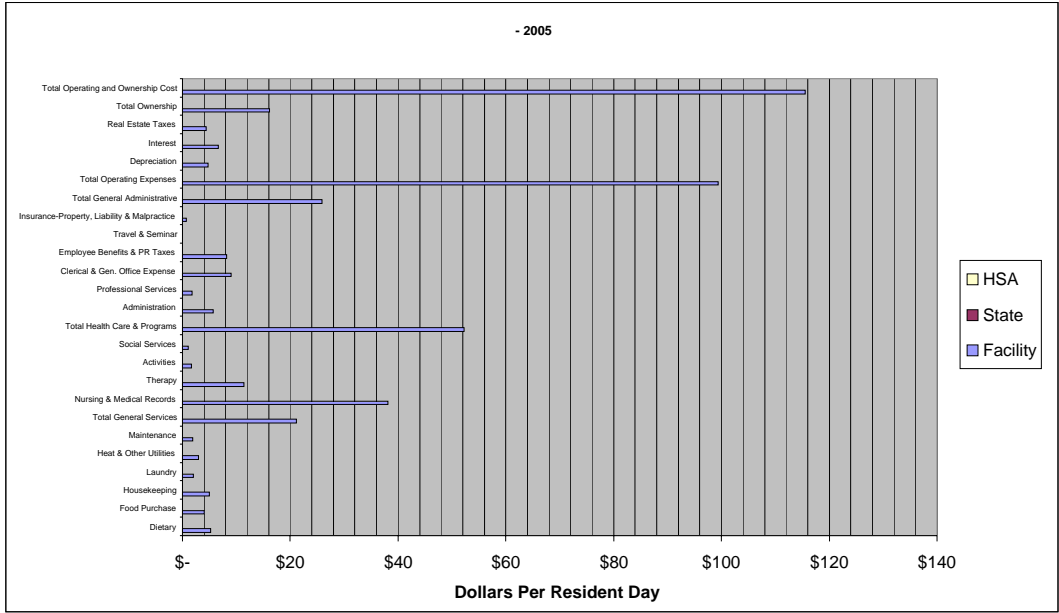


Cost Report Line	Description	2005			2004			2003			2002		
		Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA
1	Dietary	5.24	-	-	#DIV/0!	-	-	#DIV/0!	6.10	5.70	#DIV/0!	6.01	5.60
2	Food Purchase	4.02	-	-	#DIV/0!	-	-	#DIV/0!	4.31	4.11	#DIV/0!	4.27	4.09
3	Housekeeping	5.02	-	-	#DIV/0!	-	-	#DIV/0!	3.70	3.61	#DIV/0!	3.65	3.48
4	Laundry	2.00	-	-	#DIV/0!	-	-	#DIV/0!	1.85	2.13	#DIV/0!	1.90	2.23
5	Heat & Other Utilities	2.96	-	-	#DIV/0!	-	-	#DIV/0!	2.95	2.95	#DIV/0!	2.71	2.73
6	Maintenance	1.95	-	-	#DIV/0!	-	-	#DIV/0!	3.01	2.82	#DIV/0!	2.99	2.92
8	Total General Services	21.19	-	-	#DIV/0!	-	-	#DIV/0!	22.58	21.73	#DIV/0!	22.09	22.04
10	Nursing & Medical Records	38.07	-	-	#DIV/0!	-	-	#DIV/0!	41.83	42.15	#DIV/0!	40.68	41.16
10A	Therapy	11.44	-	-	#DIV/0!	-	-	#DIV/0!	2.10	2.24	#DIV/0!	1.85	2.27
11	Activities	1.63	-	-	#DIV/0!	-	-	#DIV/0!	1.91	1.54	#DIV/0!	1.88	1.60
12	Social Services	1.06	-	-	#DIV/0!	-	-	#DIV/0!	1.42	1.27	#DIV/0!	1.44	1.32
16	Total Health Care & Programs	\$2.24	-	-	#DIV/0!	-	-	#DIV/0!	49.48	49.49	#DIV/0!	47.55	47.76
17	Administration	5.68	-	-	#DIV/0!	-	-	#DIV/0!	3.36	3.17	#DIV/0!	3.39	3.54
19	Professional Services	1.77	-	-	#DIV/0!	-	-	#DIV/0!	0.99	0.77	#DIV/0!	0.98	0.72
21	Clerical & Gen. Office Expense	9.06	-	-	#DIV/0!	-	-	#DIV/0!	4.79	4.25	#DIV/0!	4.58	4.31
22	Employee Benefits & PR Taxes	8.18	-	-	#DIV/0!	-	-	#DIV/0!	10.09	9.08	#DIV/0!	9.63	8.44
24	Travel & Seminar	0.05	-	-	#DIV/0!	-	-	#DIV/0!	0.08	0.07	#DIV/0!	0.09	0.09
26	Insurance-Property, Liability & Malpractice	0.73	-	-	#DIV/0!	-	-	#DIV/0!	2.58	2.61	#DIV/0!	2.19	2.03
28	Total General Administrative	25.94	-	-	#DIV/0!	-	-	#DIV/0!	24.94	22.93	#DIV/0!	23.47	21.93
29	Total Operating Expenses	99.37	-	-	#DIV/0!	-	-	#DIV/0!	98.06	94.71	#DIV/0!	94.39	91.33
30	Depreciation	4.74	-	-	#DIV/0!	-	-	#DIV/0!	3.70	3.38	#DIV/0!	3.53	3.04
32	Interest	6.60	-	-	#DIV/0!	-	-	#DIV/0!	2.54	1.50	#DIV/0!	2.73	1.54
33	Real Estate Taxes	4.35	-	-	#DIV/0!	-	-	#DIV/0!	1.38	1.11	#DIV/0!	1.30	1.03
37	Total Ownership	16.17	-	-	#DIV/0!	-	-	#DIV/0!	11.11	8.39	#DIV/0!	11.44	10.00
	Total Operating and Ownership Cost	115.55	-	-	#DIV/0!	-	-	#DIV/0!	###	103.10	#DIV/0!	105.83	101.30

Notes:

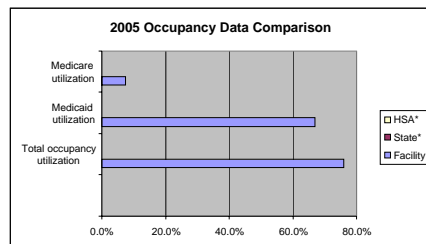
Your Facility data is from page 3, column 8 of each of your respective Medicaid cost reports, divided by the respective annual census.

The 2005, 2004, 2003 & 2002 Median Cost Per Day for the State and your HSA is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.



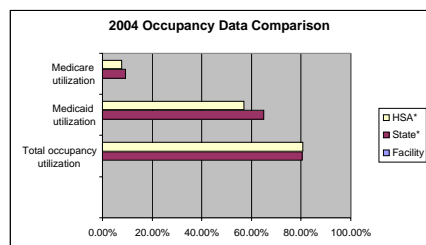
2005

	Your	State*	HSA*
	Facility		
Total occupancy utilization	75.88%	0.00%	0.00%
Medicaid utilization	66.87%	0.00%	0.00%
Medicare utilization	7.49%	0.00%	0.00%
Private pay percent utilization	1.44%	N/A	N/A
Capacity in Patient Days	54,750	N/A	N/A
Census days of service provided	41,546	N/A	N/A



2004

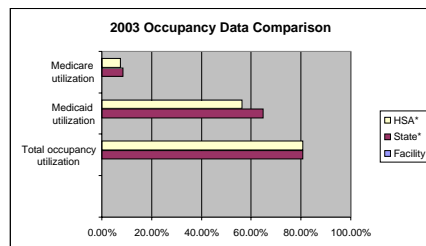
	Your	State*	HSA*
	Facility		
Total occupancy utilization	#DIV/0!	80.50%	80.70%
Medicaid utilization	#DIV/0!	65.00%	57.00%
Medicare utilization	#DIV/0!	9.40%	7.70%
Private pay percent utilization	#DIV/0!	N/A	N/A
Capacity in Patient Days		N/A	N/A
Census days of service provided		N/A	N/A



* State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

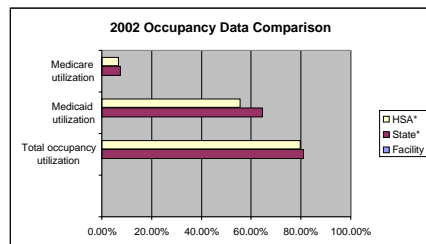
2003

	Your	State*	HSA*
	Facility		
Total occupancy utilization	#DIV/0!	80.80%	80.80%
Medicaid utilization	#DIV/0!	64.80%	56.40%
Medicare utilization	#DIV/0!	8.50%	7.50%
Private pay percent utilization	#DIV/0!	N/A	N/A
Capacity in Patient Days		N/A	N/A
Census days of service provided		N/A	N/A

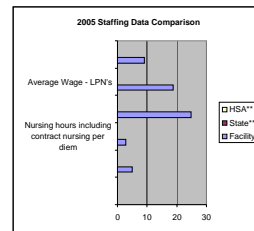


2002

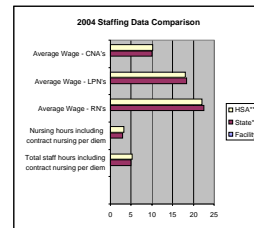
	Your	State*	HSA*
	Facility		
Total occupancy utilization	#DIV/0!	80.90%	79.60%
Medicaid utilization	#DIV/0!	64.50%	55.50%
Medicare utilization	#DIV/0!	7.40%	6.80%
Private pay percent utilization	#DIV/0!	N/A	N/A
Capacity in Patient Days		N/A	N/A
Census days of service provided		N/A	N/A



2005			
Your			
Facility	State**	HSA**	
Total staff hours including contract nursing per diem	4.95	0.00	0.00
Nursing hours including contract nursing per diem	2.87	0.00	0.00
Average Wage - RN's	24.9	0.00	0.00
Average Wage - LPN's	18.86	0.00	0.00
Average Wage - CNA's	9.15	0.00	0.00

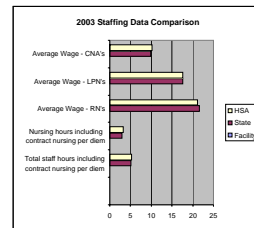


2004			
Your			
Facility	State**	HSA**	
Total staff hours including contract nursing per diem	5.00	5.30	
Nursing hours including contract nursing per diem	3.00	3.20	
Average Wage - RN's	22.54	22.05	
Average Wage - LPN's	18.40	18.02	
Average Wage - CNA's	10.02	10.13	

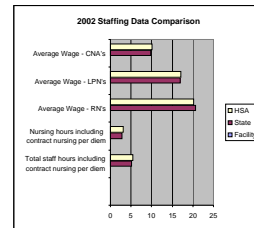


** State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

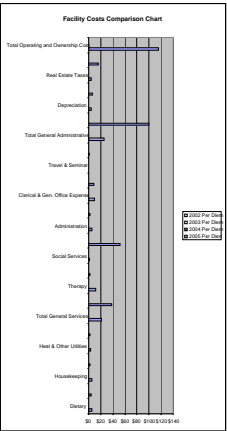
2003			
Your			
Facility	State	HSA	
Total staff hours including contract nursing per diem	5.10	5.30	
Nursing hours including contract nursing per diem	2.90	3.20	
Average Wage - RN's	21.56	21.14	
Average Wage - LPN's	17.64	17.65	
Average Wage - CNA's	9.91	10.11	



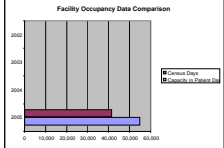
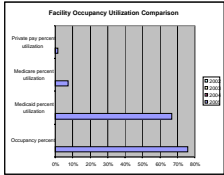
2002			
Your			
Facility	State	HSA	
Total staff hours including contract nursing per diem	5.20	5.50	
Nursing hours including contract nursing per diem	2.80	3.10	
Average Wage - RN's	20.69	20.12	
Average Wage - LPN's	16.89	17.04	
Average Wage - CNA's	9.73	10.05	



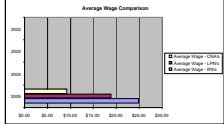
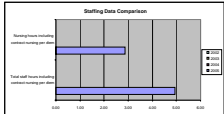
Report Line	Allocation	Year			
		Facility 2003		Facility 2004	
		Per Show	Per Show	Per Show	Per Show
1	Stency	5.24	4500/01	4500/01	4500/01
2	Food Purchase	4.02	4500/01	4500/01	4500/01
3	Housekeeping	5.62	4500/01	4500/01	4500/01
4	Landsc	1.98	4500/01	4500/01	4500/01
5	Heat & Other Utilities	2.94	4500/01	4500/01	4500/01
6	Maintenance	1.05	4500/01	4500/01	4500/01
8	Total General Services	23.84	4500/01	4500/01	4500/01
10	Nursing & Medical Records	38.07	4500/01	4500/01	4500/01
10A	Therapy	31.45	4500/01	4500/01	4500/01
11	Activities	1.62	4500/01	4500/01	4500/01
12	Social Services	1.04	4500/01	4500/01	4500/01
16	Total Health Care & Programs	72.24	4500/01	4500/01	4500/01
17	Administration	5.68	4500/01	4500/01	4500/01
19	Professional Services	1.77	4500/01	4500/01	4500/01
21	Child & Gen. Office Expense	9.06	4500/01	4500/01	4500/01
22	Employee Benefits & FR Taxes	4.35	4500/01	4500/01	4500/01
24	Travel & Lodging	0.05	4500/01	4500/01	4500/01
26	Insurance-Property, Liability & Malpractice	6.73	4500/01	4500/01	4500/01
26	Total General Administration	22.64	4500/01	4500/01	4500/01
29	Total Operating Expenses	90.37	4500/01	4500/01	4500/01
30	Depreciation	4.74	4500/01	4500/01	4500/01
32	Interest	4.48	4500/01	4500/01	4500/01
33	Real Estate Taxes	4.37	4500/01	4500/01	4500/01
37	Total Ownership	13.67	4500/01	4500/01	4500/01
Total Operating and Ownership Cost		135.15	4500/01	4500/01	4500/01



	Facility 2003	Facility 2004	Facility 2005	Facility 2006
Occupancy percent	75.98%	4500/01	4500/01	4500/01
Medicaid percent utilization	68.87%	4500/01	4500/01	4500/01
Medicare percent utilization	7.49%	4500/01	4500/01	4500/01
Private pay percent utilization	14.9%	4500/01	4500/01	4500/01
Capacity in Patient Days	58,750	0	0	0
Census Days	49,346	0	0	0



	Facility 2003	Facility 2004	Facility 2005	Facility 2006
Total staff hours including contract nursing per day	4.95	0.00	0.00	0.00
Nursing hours including contract nursing per show	2.87	0.00	0.00	0.00
Average Wage - BNY	24.90	0.00	0.00	0.00
Average Wage - LPRN	18.80	0.00	0.00	0.00
Average Wage - CNNA	9.15	0.00	0.00	0.00



	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	201,007	12,543	3,951	217,501	0	217,501	0	217,501
2. Food Purchase	0	170,812	0	170,812	0	170,812	-3,939	166,873
3. Housekeeping	140,727	67,646	0	208,373	0	208,373	280	208,653
4. Laundry	58,669	24,430	0	83,099	0	83,099	0	83,099
5. Heat and Other Utilities	0	0	121,029	121,029	0	121,029	1,993	123,022
6. Maintenance	29,872	37,320	13,246	80,438	0	80,438	621	81,059
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	430,275	312,751	138,226	881,252	0	881,252	-1,045	880,207
9. Medical Director	0	0	2,100	2,100	0	2,100	0	2,100
10. Nursing & Medical Records	1,537,939	40,990	4,400	1,583,329	0	1,583,329	-1,584	1,581,745
10a. Therapy	0	0	475,105	475,105	0	475,105	0	475,105
11. Activities	61,758	5,896	0	67,654	0	67,654	0	67,654
12. Social Services	43,871	0	0	43,871	0	43,871	0	43,871
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,643,568	46,886	481,605	2,172,059	0	2,172,059	-1,584	2,170,475
17. Administrative	125,692	0	243,250	368,942	0	368,942	-132,929	236,013
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	73,703	73,703	0	73,703	-332	73,371
20. Fees, Subscriptions & Promotion	0	0	3,354	3,354	0	3,354	12	3,366
21. Clerical & General Office	275,072	0	33,141	308,213	0	308,213	68,301	376,514
22. Employee Benefits & Payroll	0	0	336,516	336,516	0	336,516	3,248	339,764
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	1,932	1,932	0	1,932	37	1,969
25. Other Admin. Staff Trans	0	0	1,471	1,471	0	1,471	324	1,795
26. Insurance-Prop.Liab.Malpractice	0	0	15,958	15,958	0	15,958	14,218	30,176
27. Other (specify)*	0	0	0	0	0	0	14,920	14,920
28. Total General Adminis	400,764	0	709,325	1,110,089	0	1,110,089	-32,201	1,077,888
29. Total General Administrative	2,474,607	359,637	1,329,156	4,163,400	0	4,163,400	-34,830	4,128,570
30. Depreciation	0	0	87,199	87,199	0	87,199	109,581	196,780
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	37,286	37,286	0	37,286	236,758	274,044
33. Real Estate	0	0	0	0	0	0	180,804	180,804
34. Rent - Facility & Grounds	0	0	600,000	600,000	0	600,000	-600,000	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	1,168	1,168
36. Other (specify):*	0	0	0	0	0	0	19,196	19,196
37. Total Ownership	0	0	724,485	724,485	0	724,485	-52,493	671,992
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	112,496	0	112,496	0	112,496	0	112,496
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	82,125	82,125	0	82,125	0	82,125
43. Other (specify):*	0	0	34,518	34,518	0	34,518	-34,518	0
44. Total Special Cost Ce	0	112,496	116,643	229,139	0	229,139	-34,518	194,621
45. Grand Total	2,474,607	472,133	2,170,284	5,117,024	0	5,117,024	-121,841	4,995,183

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,000	149,670
2. Cash - Patient Deposits	13,731	13,731
3. Accounts & Notes Recievable	1,087,537	1,087,537
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	30,432	54,801
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	262,881	450,205
10. Total current assets	1,395,581	1,755,944
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	230,000
14. Buildings, at Historical Cost	0	2,789,222
15. Leasehold Improvements, Historical Cost	372,302	703,751
16. Equipment, at Historical Cost	353,109	852,767
17. Accumulated Depreciation (book methods)	-411,843	-991,487
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	133,876
23. other (specify):	0	0
24. Total Long-Term Assets	313,568	3,718,129
25. Total Assets	1,709,149	5,474,073
CURRENT LIABILITIES		
26. Accounts Payable	150,401	157,135
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	22,822	22,822
29. Short-Term Notes Payable	643,740	643,740
30. Accrued Salaries Payable	121,901	121,901
31. Accrued Taxes Payable	16,090	16,090
32. Accrued Real Estate Taxes	0	165,000
33. Accrued Interest Payable	0	95,534
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	534,796	135,694
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,489,750	1,357,916
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	4,086,332
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	4,086,332
46.Total Liabilities	1,489,750	5,444,248
47.Total Equity	219,399	29,825
48.Total Liabilities and Equity	1,709,149	5,474,073

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	4,924,883
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	4,924,883
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	334,111
7. Oxygen	15,329
Subtotal - Ancillary Revenue	349,440
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	9,244
Subtotal - Non-Operating Revenue	9,244
27. Other Revenue (specify):	1,288
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,288
30. Total Revenue	5,284,855
31. General Services	881,252
32. Health Care	2,172,059
33. General Administration	1,110,089
34. Ownership	724,485
35. Special Cost Centers	147,014
35. Provider Participation Fee	82,125
37. Other	0
40. Total Expenses	5,117,024
41. Income Before Income Taxes	167,831
42. Income Taxes	0
43. Net Income or Loss for the Year	167,831

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LTC Median Per Diem Cost by HSA - 2005 Cost Reports
2005 (Run June 1, 2004)

Cahokia Nursing & Rehabilitat ion Center	Cahokia Nursing & Rehabilita tion Center
2005 Costs	

Report	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	2101	2102	2103	2104	2105	2106	2107	2108	2109	2110	2111	2112	2113	2114	2115	2116	2117	2118	2119	2120	2121	2122	2123	2124	2125	2126	2127	2128	2129	2130	2131	2132	2133	2134	2135	2136	2137	2138	2139	2140	2141	2142	2143	2144	2145	2146	2147	2148	2149	2150	2151	2152	2153	2154	2155	2156	2157	2158	2159	2160	2161	2162	2163	2164	2165	2166	2167	2168	2169	2170	2171	2172	2173	2174	2175	2176	2177	2178	2179	2180	2181	2182	2183	2184	2185	2186	2187	2188	2189	2190	2191	2192	2193	2194	2195	2196	2197	2198	2199	2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220	2221	2222	2223	2224	2225	2226	2227	2228	2229	2230	2231	2232	2233	2234	2235	2236	2237	2238	2239	2240	2241	2242	2243	2244	2245	2246	2247	2248	2249	2250	2251	2252	2253	2254	2255	2256	2257	2258	2259	2260	2261	2262	2263	2264	2265	2266	2267	2268	2269	2270	2271	2272	2273	2274	2275	2276	2277	2278	2279	2280	2281	2282	2283	2284	2285	2286	2287	2288	2289	2290	2291	2292	2293	2294	2295	2296	2297	2298	2299	2300	2301	2302	2303	2304	2305	2306	2307	2308	2309	2310	2311	2312	2313	2314	2315	2316	2317	2318	2319	2320	2321	2322	2323	2324	2325	2326	2327	2328	2329	2330	2331	2332	2333	2334	2335	2336	2337	2338	2339	2340	2341	2342	2343	2344	2345	2346	2347	2348	2349	2350	2351	2352	2353	2354	2355	2356	2357	2358	2359	2360	2361	2362	2363	2364	2365	2366	2367	2368	2369	2370	2371	2372	2373	2374	2375	2376	2377	2378	2379	2380	2381	2382	2383	2384	2385	2386	2387	2388	2389	2390	2391	2392	2393	2394	2395	2396	2397	2398	2399	2400	2401	2402	2403	2404	2405	2406	2407	2408	2409	2410	2411	2412	2413	2414	2415	2416	2417	2418	2419	2420	2421	2422	2423	2424	2425	2426	2427	2428	2429	2430	2431	2432	2433	2434	2435	2436	2437	2438	2439	2440	2441	2442	2443	2444	2445	2446	2447	2448	2449	2450	2451	2452	2453	2454	2455	2456	2457	2458	2459	2460	2461	2462	2463	2464	2465	2466	2467	2468	2469	2470	2471	2472	2473	2474	2475	2476	2477	2478	2479	2480	2481	2482	2483	2484	2485	2486	2487	2488	2489	2490	2491	2492	2493	2494	2495	2496	2497	2498	2499	2500	2501	2502	2503	2504	2505	2506	2507	2508	2509	2510	2511	2512	2513	2514	2515	2516	2517	2518	2519	2520	2521	2522	2523	2524	2525	2526	2527	2528	2529	2530	2531	2532	2533	2534	2535	2536	2537	2538	2539	2540	2541	2542	2543	2544	2545	2546	2547	2548	2549	2550	2551	2552	2553	2554	2555	2556	2557	2558	2559	2560	2561	2562	2563	2564	2565	2566	2567	2568	2569	2570	2571	2572	2573	2574	2575	2576	2577	2578	2579	2580	2581	2582	2583	2584	2585	2586	2587	2588	2589	2590	2591	2592	2593	2594	2595	2596	2597	2598	2599	2600	2601	2602	2603	2604	2605	2606	2607	2608	2609	2610	2611	2612	2613	2614	2615	2616	2617	2618	2619	2620	2621	2622	2623	2624	2625	2626	2627	2628	2629	2630	2631	2632	2633	2634	2635	2636	2637	2638	2639	2640	2641	2642	2643	2644	2645	2646	2647	2648	2649	2650	2651	2652	2653	2654	2655	2656	2657	2658	2659	2660	2661	2662	2663	2664	2665	2666	2667	2668	2669	2670	2671	2672	2673	2674	2675	2676	2677	2678	2679	2680	2681	2682	2683	2684	2685	2686	2687	2688	2689	2690	2691	2692	2693	2694	2695	2696	2697	2698	2699	2700	2701	2702	2703	2704	2705	2706	2707	2708	2709	2710	2711	2712	2713	2714	2715	2716	2717	2718	2719	2720	2721	2722	2723	2724	2725	2726	2727	2728	2729	2730	2731	2732	2733	2734	2735	2736	2737	2738	2739	2740	2741	2742	2743	2744	2745	2746	2747	2748	2749	2750	2751	2752	2753	2754	2755	2756	2757	2758	2759	2760	2761	2762	2763	2764	2765	2766	2767	2768	2769	2770	2771	2772	2773	2774	2775	2776	2777	2778	2779	2780	2781	2782	2783	2784	2785	2786	2787	2788	2789	2790	2791	2792	2793	2794	2795	2796	2797	2798	2799	2800	2801	2802	2803	2804	2805	2806	2807	2808	2809	2810	2811	2812	2813	2814	2815	2816	2817	2818	2819	2820	2821	2822	2823	2824	2825	2826	2827	2828	2829	2830	2831	2832	2833	2834	2835	2836	2837	2838	2839	2840	2841	2842	2843	2844	2845	2846	2847	2848	2849	2850	2851	2852	2853	2854	2855	2856	2857	2858	2859	2860	2861	2862	2863	2864	2865	2866	2867	2868	2869	2870	2871	2872	2873	2874	2875	2876	2877	2878	2879	2880	2881	2882	2883	2884	2885	2886	2887	2888	2889	2890	2891	2892	2893	2894	2895	2896	2897	2898	2899	2900	2901	2902	2903	2904	2905	2906	2907	2908	2909	2910	2911	2912	2913	2914	2915	2916	2917	2918	2919	2920	2921	2922	2923	2924	2925	2926	2927	2928	2929	2930	2931	2932	2933	2934	2935	2936	2937	2938	2939	2940	2941	2942	2943	2944	2945	2946	2947	2948	2949	2950	2951	2952	2953	2954	2955	2956	2957	2958	2959	2960	2961	2962	2963	2964	2965	2966	2967	2968	2969	2970	2971	2972	2973	2974	2975	2976	2977	2978	2979	2980	2981	2982	2983	2984	2985	2986	2987	2988	2989	2990	2991	2992	2993	2994	2995	2996	2997	2998	2999	3000

State-Wide

HSA 1 HSA 2 HSA 3 HSA 4 HSA 5 HSA 6 HSA 7 HSA 8 HSA 9 HSA 10 HSA 11

State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11

LTC Median Per Diem Cost by HSA - 2004 Cost Reports
2004 (Run June 1, 2004)

UN-INFLATED

Cost	Report
<u>Line</u>	<u>Description</u>
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
32	Depreciation
33	Interest
32	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

**Cahokia
Nursing &
Rehabilita
tion
Center
2004
Costs**

**Cahokia
Nursing
&
Rehabilit
ation
Center
2004
Census**

	State- Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Total staff hours including contract nurses per diem	5.00	5.30	5.30	5.30	5.30	5.10	4.80	4.80	4.80	5.10	5.30	5.20
Nursing hours including contract nurses per diem	3.00	3.20	3.20	3.30	3.20	3.10	2.80	2.80	2.80	3.10	3.20	3.10
LPN	22.54	22.05	20.73	19.72	20.73	17.47	25.72	25.72	25.72	23.44	22.05	20.43
RN	18.4	18.02	17.23	15.4	17.23	13.82	21.06	21.06	21.06	19.89	18.02	17.12
CNA	10.02	10.13	10.03	9.32	10.03	8.4	10.52	10.52	10.52	9.84	10.13	9.84
DON	28.97	23.98	25.17	23.86	25.17	22.23	34.39	34.39	34.39	30.41	23.98	25.97
ADON	25.23	23.95	21.85	19.41	21.85	19.13	28.74	28.74	28.74	26.68	23.95	23.97

	State- Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Average Occupancy	80.50%	80.70%	80.40%	78.10%	80.40%	74.40%	81.80%	81.80%	81.80%	82.90%	80.70%	78.20%
Medicaid Utilization	65.00%	57.00%	56.70%	58.50%	56.70%	61.80%	70.60%	70.60%	70.60%	64.50%	57.00%	60.60%
Medicare Utilization	9.40%	7.70%	8.90%	9.30%	8.90%	8.80%	9.90%	9.90%	9.90%	13.00%	7.70%	8.90%

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004)

UN-INFLATED

Cahokia
Nursing &
Rehabilitati
on Center
Cahokia
Nursing
&
Rehabilitati
on Center
2003
Census

Cost Report Line	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.10	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	TOTAL GENERAL SERVICES	22.58	24.49	22.99	21.14	22.99	21.47	22.65	22.65	22.65	22.45	24.49	21.73	17.57	31.51
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	49.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	49.49	32.10	77.23
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	22.93	16.95	39.14
29	TOTAL OPERATING EXPENSES	98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	94.71	69.40	142.56
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	TOTAL OWNERSHIP	11.11	9.73	9.80	8.00	9.80	7.04	14.54	14.54	14.54	11.02	9.73	8.39	3.76	23.58
	TOTAL OPERATING & OWNERSHIP COST	109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	103.10	73.16	166.14

Cost Report Line	Description	10th %	90th %
1	Dietary	4.13	9.81
2	Food Purchase	3.36	6.04
3	Housekeeping	2.48	5.80
4	Laundry	0.91	3.14
5	Heat & Other Utilities	2.05	4.25
6	Maintenance	1.92	5.12
8	TOTAL GENERAL SERVICES	17.57	31.51
10	Nursing & Medical Records	27.25	64.47
10A	Therapy	-	10.55
11	Activities	1.06	3.45
12	Social Services	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	32.10	77.23
17	Administration	1.71	7.21
19	Professional Services	0.07	3.44
21	Clerical & Gen. Office Expense	2.49	10.78
22	Employee Benefits & PR Taxes	6.33	19.34
24	Travel & Seminar	-	0.43
26	Insurance-Property, liability & Malpractice	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	16.95	39.14
29	TOTAL OPERATING EXPENSES	69.40	142.56
30	Depreciation	1.01	8.43
32	Interest	-	11.53
33	Real Estate Taxes	-	4.85
37	TOTAL OWNERSHIP	3.76	23.58
	TOTAL OPERATING & OWNERSHIP COST	73.16	166.14

Average Wage Data Table

	State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	
		1	2	3	4	5	6	7	8	9	10	11
Total staff hours including contract nurses per diem	5.10	5.30	5.30	5.00	5.30	5.10	4.90	4.90	4.90	5.10	5.30	5.30
Nursing hours including contract nurses per diem	2.90	3.20	3.10	3.10	3.10	3.00	2.70	2.70	2.70	3.00	3.20	3.10
RN	21.56	21.14	19.99	18.79	19.99	16.66	24.55	24.55	24.55	22.85	21.14	20.33
LPN	17.64	17.65	16.41	14.79	16.41	13.36	20.23	20.23	20.23	18.67	17.65	16.45
CNA	9.91	10.11	9.89	9.19	9.89	8.28	10.44	10.44	10.44	10.54	10.11	9.76
DON	27.82	26.67	24.49	23.07	24.49	20.82	33.29	33.29	33.29	29.65	26.67	24.62
ADON	24.39	22.67	21.12	19.67	21.12	18.73	27.45	27.45	27.45	26.14	22.67	22.50

2003 - Staffing and Occupancy Data

	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Average Occupancy	80.80%	80.80%	80.60%	79.90%	80.60%	75.20%	82.00%	82.00%	82.00%	81.60%	80.80%	77.30%
Medicaid Utilization	64.80%	56.40%	57.70%	59.60%	57.70%	62.80%	70.00%	70.00%	70.00%	64.30%	56.40%	59.30%
Medicare Utilization	8.50%	7.50%	7.50%	7.70%	7.50%	8.70%	9.10%	9.10%	9.10%	9.30%	7.50%	8.00%

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2002 Cost Reports
2002 (Run June 1, 2004)

UN-INFLATED

Cost Report	State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	10th %	90th %
Line	Description	1	2	3	4	5	6	7	8	9	10	11		
1	Dietary	6.01	7.28	6.51	5.36	6.51	5.48	5.92	5.92	5.83	7.28	5.60	4.17	9.77
2	Food Purchase	4.27	4.52	4.40	4.15	4.40	3.99	4.31	4.31	4.31	4.11	4.52	3.29	5.90
3	Housekeeping	3.65	3.84	3.56	3.05	3.56	3.25	4.13	4.13	3.89	3.84	3.48	2.51	5.63
4	Laundry	1.90	2.15	2.01	1.72	2.01	2.09	1.67	1.67	1.58	2.15	2.23	1.10	3.13
5	Heat & Other Utilities	2.71	2.84	2.76	2.75	2.76	2.54	2.67	2.67	2.72	2.84	2.73	1.89	4.03
6	Maintenance	2.99	3.41	2.96	2.91	2.96	2.48	3.16	3.16	2.90	3.41	2.92	1.95	5.11
8	TOTAL GENERAL SERVICES	22.09	24.39	22.49	20.85	22.49	20.47	22.71	22.71	22.66	24.39	22.04	17.19	30.80
10	Nursing & Medical Records	40.68	42.79	42.10	37.44	42.10	33.35	43.96	43.96	43.84	42.79	41.16	26.11	62.04
10A	Therapy	1.85	1.90	2.38	2.86	2.38	1.81	1.54	1.54	3.02	1.90	2.27	-	10.03
11	Activities	1.88	2.12	1.89	1.50	1.89	1.37	2.23	2.23	2.10	2.12	1.60	1.13	3.39
12	Social Services	1.44	1.46	1.50	1.08	1.50	1.13	1.61	1.61	1.32	1.46	1.32	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	47.55	50.19	49.32	44.36	49.32	39.56	50.57	50.57	52.75	50.19	47.76	31.31	74.79
17	Administration	3.39	3.49	3.30	3.27	3.30	3.61	3.39	3.39	3.20	3.49	3.54	1.65	6.84
19	Professional Services	0.98	1.00	0.76	0.88	0.76	0.98	1.05	1.05	1.05	1.19	1.00	0.07	2.93
21	Clerical & Gen. Office Expense	4.58	4.07	4.40	3.67	4.40	3.47	5.75	5.75	4.19	4.07	4.31	2.36	10.72
22	Employee Benefits & PR Taxes	9.63	10.11	10.26	8.28	10.26	7.80	10.26	10.26	9.30	10.11	8.44	6.22	17.51
24	Travel & Seminar	0.09	0.12	0.10	0.09	0.10	0.16	0.06	0.06	0.03	0.12	0.09	-	0.37
26	Insurance-Property, liability & Malpractice	2.19	1.93	1.97	1.87	1.97	2.00	2.46	2.46	2.40	1.93	2.03	0.83	3.92
28	TOTAL GENERAL ADMINISTRATIVE	23.47	23.64	24.80	21.32	24.80	20.28	25.17	25.17	23.10	23.64	21.93	16.13	36.02
29	TOTAL OPERATING EXPENSES	94.39	99.26	97.46	85.50	97.46	82.47	99.35	99.35	97.86	99.26	91.33	67.15	138.58
30	Depreciation	3.53	3.13	3.86	3.26	3.86	2.41	4.18	4.18	3.94	3.13	3.04	0.73	8.09
32	Interest	2.73	2.84	2.05	2.60	2.05	1.55	4.55	4.55	2.14	2.84	1.54	-	12.86
33	Real Estate Taxes	1.30	0.77	0.88	0.93	0.88	0.72	3.17	3.17	1.29	0.77	1.03	-	5.05
37	TOTAL OWNERSHIP	11.44	9.19	9.85	8.76	9.85	6.52	15.35	15.35	11.40	9.19	10.00	3.55	24.50
	TOTAL OPERATING & OWNERSHIP COST	105.83	108.45	107.31	94.26	107.31	88.99	114.70	114.70	109.26	108.45	101.30	70.70	163.08

Cost Report	2002 Costs	2002 Census
Line	Description	
1	Dietary	
2	Food Purchase	
3	Housekeeping	
4	Laundry	
5	Heat & Other Utilities	
6	Maintenance	
8	TOTAL GENERAL SERVICES	
10	Nursing & Medical Records	
10A	Therapy	
11	Activities	
12	Social Services	
16	TOTAL HEALTH CARE & PROGRAMS	
17	Administration	
19	Professional Services	
21	Clerical & Gen. Office Expense	
22	Employee Benefits & PR Taxes	
24	Travel & Seminar	
26	Insurance-Property, liability & Malpractice	
28	TOTAL GENERAL ADMINISTRATIVE	
29	TOTAL OPERATING EXPENSES	
30	Depreciation	
32	Interest	
33	Real Estate Taxes	
37	TOTAL OWNERSHIP	
	TOTAL OPERATING & OWNERSHIP COST	

2002 - Average Wage Data Table

State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11
Total staff hours including contract nursing per diem	5.20	5.50	5.40	5.00	5.40	5.10	5.00	5.00	4.90	5.50	5.30
Nursing hours including contract nurses per diem	2.80	3.10	3.10	3.00	3.10	2.90	2.60	2.60	2.60	3.10	3.00
RN	20.69	20.12	19.18	18.37	19.18	16.06	23.49	23.49	23.49	21.31	19.45
LPN	16.89	17.04	15.72	14.33	15.72	12.75	19.39	19.39	19.39	17.96	15.69
CNA	9.73	10.05	9.65	9.09	9.65	8.08	10.28	10.28	10.28	10.39	10.05
DON	26.38	24.75	22.98	22.48	22.98	20.02	31.78	31.78	31.78	28.56	23.68
ADON	23.27	21.44	20.51	18.93	20.51	17.26	26.34	26.34	26.34	24.33	21.27

2002 - Staffing and Occupancy Data

State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11
Average Occupancy	80.90%	79.60%	81.90%	80.30%	81.90%	75.30%	82.20%	82.20%	82.20%	79.60%	76.60%
Medicaid Utilization	64.50%	55.50%	56.10%	58.50%	56.10%	63.30%	69.90%	69.90%	66.70%	55.50%	60.90%
Medicare Utilization	7.40%	6.80%	7.20%	6.10%	7.20%	7.40%	7.70%	7.70%	8.20%	6.80%	7.00%